MRMIP STATUTE

CALIFORNIA CODES
INSURANCE CODE
SECTIONS 12700-12739

12700. The Legislature finds and declares all of the following:
(a) That many Californians, do not have employer-sponsored group health coverage and are unable to secure adequate health coverage for themselves and their dependents because of preexisting medical conditions, and a number of employer sponsored groups have difficulty obtaining or maintaining their health coverage because some members of the group either have or are viewed as being at risk for having high medical costs.
(b) That, even where uninsured persons with preexisting conditions are able to secure coverage, the cost of coverage is prohibitively high or is secured only by waiving coverage for the preexisting conditions for which they are most likely to need care.
(c) That adverse selection precludes private health plans regulated by the State of California from enrolling medically uninsurable persons in the face of the escalating health care costs, and a highly competitive market.
(d) That, left to face the cost of major medical care without health coverage, all but the extremely affluent uninsured persons must ultimately look to publicly funded programs including Medi-Cal or MISP in the event of severe illness or injury.
(e) That a prudent means of making major medical coverage available to individuals presently unable to purchase it, is to subsidize their purchase of private health coverage from participating health plans.
(f) That a prudent means of making major medical coverage available to groups presently unable to purchase or having difficulty maintaining major medical coverage is to facilitate purchase of private health coverage from participating health plans.

12705. For the purposes of this part, the following terms have the following meanings:
(a) "Applicant" means an individual who applies for major risk medical coverage through the program.
(b) "Board" means the Managed Risk Medical Insurance Board.
(c) "Fund" means the Major Risk Medical Insurance Fund, from which the program may authorize expenditures to pay for medically necessary services which exceed subscribers' contributions, and for administration of the program.
(d) "Major risk medical coverage" means the payment for medically

necessary services provided by institutional and professional providers.

(e) "Participating health plan" means a private insurer (1) holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and (2) which contracts with the program to administer major risk medical coverage to program subscribers.

(f) "Plan rates" means the total monthly amount charged by a participating health plan for a category of risk.

(g) "Program" means the California Major Risk Medical Insurance Program.

(h) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program, and includes a member of a federally recognized California Indian tribe.

(i) "Subscriber contribution" means the portion of participating health plan rates paid by the subscriber, or paid on behalf of the subscriber by a federally recognized California Indian tribal government. If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health plan options available in the county where the member resides.

12710. The California Major Risk Medical Insurance Program is hereby created in the Health and Welfare Agency. The program shall be managed by the Major Risk Medical Insurance Board. The board shall consist of seven members, five of whom shall be appointed as follows:

The Governor shall appoint three members, subject to confirmation by the Senate, and shall designate one of these appointees as chair of the board. The Senate Committee on Rules shall appoint one member. The Speaker of the Assembly shall appoint one member. The terms of appointment shall be four years.

The Secretary of Business, Transportation, and Housing, or his or her designee, and the Secretary of Health and Welfare, or his or her designee, shall serve on the board as ex officio, nonvoting members.

The board shall appoint an executive director for the board, who shall serve at the pleasure of the board. The executive director shall receive the salary established by the Department of

Personnel Administration for exempt officials. The executive director shall administer the affairs of the board as directed by the board, and shall direct the staff of the board. The executive director may appoint, with the approval of the board, staff necessary to carry out the provisions of this part.

12710.1. The Major Risk Medical Insurance Board is hereby renamed the Managed Risk Medical Insurance Board. Any contract or agreement entered into by the Major Risk Medical Insurance Board shall constitute contracts or agreements entered into by the Managed Risk Medical Insurance Board. Any reference in any statute, regulation, contract, or any other document to the Major Risk Medical Insurance Board as of the effective date of this act shall be deemed a reference to the Managed Risk Medical Insurance Board.

12711. The board shall have the authority:

(a) To determine the eligibility of applicants.

(b) To determine the major risk medical coverage to be provided program subscribers.

(c) To research and assess the needs of persons not adequately covered by existing private and public health care delivery systems and promote means of assuring the availability of adequate health care services.

(d) To approve subscriber contributions, and plan rates, and establish program contribution amounts.

(e) To provide major risk medical coverage for subscribers or to contract with a participating health plan or plans to provide or administer major risk medical coverage for subscribers.

(f) To authorize expenditures from the fund to pay program expenses which exceed subscriber contributions.

(g) To contract for administration of the program or any portion thereof with any public agency, including any agency of state government, or with any private entity.

(h) To issue rules and regulations to carry out the purposes of this part.

(i) To authorize expenditures from the fund or from other moneys appropriated in the annual Budget Act for purposes relating to Section 10127.15 of this code or Section 1373.62 of the Health and Safety Code.

(j) To exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon it under this part.

12711.5. The board shall include a promotional component in the administrative costs of the program. This component shall include reasonable costs of advertising and other appropriate means of notifying the public of the program. Any state agency requested by the board shall provide assistance in implementing this promotional component of the program.

12712. The board shall, pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), adopt all necessary rules and regulations to carry out this part, including the following:

(a) Establishing the scope and content of adequate major medical coverage.

(b) Determining reasonable minimum standards for participating health plans.

(c) Determining the time, manner, method, and procedures for withdrawing program approval from a plan.

(d) Researching and assessing the needs of persons without adequate health coverage, and promoting means of assuring the availability of adequate health care services.

(e) Administering the program so as to ensure that the program subsidy amount does not exceed amounts transferred to the fund pursuant to Chapter 8 (commencing with Section 12739).

(f) Issuing appropriate rules and regulations for any other matters it may be authorized or required to provide for by this part. In adopting these rules and regulations, the board shall be guided by the needs and welfare of persons unable to secure adequate health coverage for themselves and their dependents, and prevailing practices among private health plans.

12712.5. (a) For the period commencing on September 1, 2003, to September 1, 2007, inclusive, the board shall maintain the major risk medical coverage benefits offered by participating health plans in the program at a level that is not less than the actuarial equivalent of the minimum benefits available within the program on September 1, 2002.

(b) This section shall become operative on September 1, 2003, and shall become inoperative on September 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the dates on which the section becomes inoperative and is repealed.

12713. Plan rates for major risk medical benefits approved for the program shall not be excessive, inadequate, or unfairly discriminatory, but shall be adequate to pay anticipated costs of claims or services and administration.

12714. There is in the program an appropriately qualified three-member physician advisory panel to be appointed by the board to provide consultation to the board on the utilization review, including peer review and quality assurance procedures of any participating health plan. The composition of the panel shall reflect the types of delivery systems providing services in this state. This consultation shall be nonbinding. The term of office of each member of this panel shall be for three years.

12725. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, "resident" includes a member of a federally recognized California Indian tribe.

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

(1) Impose substantial waivers that the program determines would leave a subscriber without adequate coverage for medically necessary services.

(2) Afford limited coverage that the program determines would leave the subscriber without adequate coverage for medically necessary services.

(3) Afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates.

(c) Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment.

(d) The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.

(e) Notwithstanding the provisions of this section, the board shall by regulation prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan pursuant to either Section 10127.15 or Section 1373.62 of the Health and Safety Code.

(f) For the period commencing September 1, 2003, to September 1, 2007, inclusive, subscribers and their dependents receiving major risk coverage through the program may receive that coverage for no more than 36 consecutive months. Ninety days before a subscriber or dependent's eligibility ceases pursuant to this subdivision, the board shall provide the subscriber and any dependents with written notice of the termination date and written information concerning the right to purchase a standard benefit plan from any health care service plan or health insurer participating in the individual insurance market pursuant to Section 10127.15 or Section 1373.62 of the Health and Safety Code. This subdivision shall become inoperative on September 1, 2007.

12715. If the board is unable to contract with participating health plans pursuant to Chapter 5 (commencing with Section 12720) the board shall issue or cause to be issued a policy of major risk medical coverage to subscribers. The policy may be offered directly by the program or by a participating health plan through a contract with the board. The contract may provide that the contracting health plan assumes full or partial risk for the cost of covered health services or that the contracting health plan undertakes only to provide administrative services. The subscriber contribution under this chapter shall not exceed 125 percent of the standard average individual rate for comparable coverage as determined by the board.

12716. The program may place a lien on compensation or benefits recovered or recoverable by a subscriber from any party or parties responsible for the compensation or benefits for which benefits have been provided under a policy issued under this chapter or Chapter 5 (commencing with Section 12720).

12717. Except as provided in Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, benefits received under this chapter or Chapter 5 (commencing with Section 12720) are in excess of and secondary to, any other form of health benefits coverage.

12718. Benefits under this chapter or Chapter 5 (commencing with Section 12720) shall be subject to required subscriber copayments and deductibles as the board may authorize. Any authorized copayments

shall not exceed 25 percent and any authorized deductible shall not exceed an annual household deductible amount of five hundred dollars ($500). However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25). If the board contracts with participating health plans pursuant to Chapter 5 (commencing with Section 12720), copayments or deductibles shall be authorized in a manner consistent with the basic method of operation of the participating health plans.

The aggregate amount of deductible and copayments payable annually under this section shall not exceed two thousand five hundred dollars ($2,500) for an individual and four thousand dollars ($4,000) for a family.

12720. The board shall provide coverage through participating health plans and may contract for the processing of applications, the enrollment of subscribers, and activities necessary to administer the program. A contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed revenue available for the program.

12721. The board may provide or purchase stop-loss coverage under which the program and participating health plans share the risk for health plan expenses which exceed plan rates.

12722. The board shall withdraw its approval of any participating health benefits plan for noncompliance with program standards, nonpayment of claims, or other good cause shown. Approval shall not be withdrawn except after reasonable notice to the health plan, program subscribers enrolled in the plan, physicians or organizations of physicians offering services through the plan, and all interested parties.

12723. The participating health plans with which the program shall contract, if available, shall include:

(a) One or more statewide service benefit plans under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services rendered to subscribers.

(b) One or more statewide indemnity benefit plans under which a carrier agrees to pay certain sums of money, not in excess of actual expenses incurred, for health services.

(c) Comprehensive group-practice prepayment plans which offer benefits, in whole or in substantial part, on a prepaid basis, with professional services thereunder provided by physicians or other providers of health services practicing as a group in a common center or centers. This group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds.

(d) Individual practice prepayment plans which offer health services in whole or in part on a prepaid basis, with professional services thereunder provided by individual physicians or other providers of health services who agree, under such conditions as may be prescribed by the board, to accept the payments provided by the plans as full payment for covered services rendered by them.

(e) Cost containment and cost reduction incentive programs which involve the subscriber as an active participant, along with the health plan and providers, in a joint effort toward containing and reducing the cost of providing medical and hospital health care services.

12725.5. (a) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759, to refer an individual employee, or his or her dependents, to the program, or arrange for an individual employee, or his or her dependents, to apply to the program, for the purpose of separating that employee, or his or her dependents, from group health coverage provided in connection with the employee's employment.

(b) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to refer an individual employee, or his or her dependents, to the program, or to arrange for an individual employee, or his or her dependents, to apply to the program, for the purpose of separating that employee, or his or her dependents, from group health coverage provided in connection with the employee's employment.

(c) As used in this section, "group health coverage" includes any nonprofit hospital service plan, health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

12726. The board may permit the exclusion of coverage or benefits for charges or expenses incurred by a subscriber during the first six months of enrollment in the program for any condition for which, during the six months immediately preceding enrollment in the program medical advice, diagnosis, care, or treatment was recommended or received as to the condition during that period.

However, the exclusion from coverage of this section shall be waived to the extent to which the subscriber was covered under any creditable coverage, as defined in Section 10900, that was terminated, provided the subscriber has applied for enrollment in the program not later than 63 days following termination of the prior coverage, or within 180 days of termination of coverage if the subscriber lost his or her previous creditable coverage because the subscriber's employment

ended, the availability of health coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward health coverage terminated. The exclusion from coverage of this section shall also be waived as to any condition of a subscriber previously receiving coverage under a plan of another state similar to the program established by this part if the subscriber was eligible for benefits under that other-state coverage for the condition. The board may establish alternative mechanisms applicable to enrollment in health plans described in subdivision (c) or (d) of Section 12723. These mechanisms may include, but are not limited to, a postenrollment waiting period.

12727. Where more than one participating health plan is offered, the program shall make available to applicants eligible to enroll in the program sufficient information to make an informed choice among the various types of participating health plans. Each applicant shall be issued an appropriate document setting forth or summarizing the services to which an enrollee is entitled, procedures for obtaining major risk medical coverage, a list of contracting health plans and providers, and a summary of grievance procedures.

12728. After the applicant notifies the program in writing of his or her choice of participating health plan, the program shall assist the applicant in enrolling as a subscriber and securing major risk medical coverage for the subscriber and any dependents.

12729. A subscriber may request a change in coverage based upon a change in the family status of any dependent, by filing an application within 30 days after the occurrence of the change in family status, or at other times and under conditions as may be prescribed by program regulations.

12730. Health coverage secured through the program shall permit a covered dependent of a subscriber to elect to continue the same coverage upon the death of the subscriber, or upon the subscriber becoming eligible for Medicare Part A and Part B.

12731. A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the program.

12732. If a subscriber is dissatisfied with any action or failure to act which has occurred in connection with a participating plan's coverage, the subscriber shall have the right to appeal to the board and shall be accorded an opportunity for a fair hearing. Hearings shall be conducted, insofar as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

12733. Subscribers and their dependents who become eligible for Part A and Part B of Medicare, excluding those on Medicare solely because of end-stage renal disease, shall not be enrolled, or continue to be enrolled, in major risk medical coverage afforded by this part.

12735. Upon enrollment as a subscriber in the program, the subscriber shall be responsible for payment of the subscriber contribution. Termination of coverage by a participating health plan for nonpayment of the subscriber contribution shall be governed by the same laws and regulations by which the participating health plan

is regulated as to all its subscribers and enrollees.

12736. Each health plan contracting with the board pursuant to Chapter 5 (commencing with Section 12720) shall submit annually to the program rates which it estimates are sufficient to cover the cost of providing major risk medical coverage to its subscribers. The rates shall be submitted on the basis of categories of risk which shall be established by the board.

12737. (a) The board shall establish program contribution amounts for each category of risk for each participating health plan. The program contribution amounts shall be based on the average amount of subsidy funds required for the program as a whole. To determine the average amount of subsidy funds required, the board shall calculate a loss ratio, including all medical costs, administration fees, and risk payments, for the program in the prior calendar year. The loss ratio shall be calculated using 125 percent of the standard average individual rates for comparable coverage as the denominator, and all medical costs, administration fees, and risk payments as the numerator. The average amount of subsidy funds required is calculated by subtracting 100 percent from the program loss ratio. For purposes of calculating the program loss ratio, no participating health plan's loss ratio shall be less than 100 percent and participating health plans with fewer than 1,000 program members shall be excluded from the calculation.

Subscriber contributions shall be established to encourage members to select those health plans requiring subsidy funds at or below the program average subsidy. Subscriber contribution amounts shall be established so that no subscriber receives a subsidy greater than the program average subsidy, except that:

(1) In all areas of the state, at least one plan shall be available to program participants at an average subscriber contribution of 125 percent of the standard average individual rates for comparable coverage.

(2) No subscriber contribution shall be increased by more than 10 percent above 125 percent of the standard average individual rates for comparable coverage.

(3) Subscriber contributions for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the standard average individual rates for comparable coverage for the first two benefit years the plan participates in the program.

(b) The program shall pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund.

12738. A participating health plan may charge subscriber contributions under this chapter which do not exceed the difference between its plan rate for the category of risk and the program contribution amount for the category of risk.

12739. (a) There is hereby created in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in Sections 10127.15 and 12739.1 and Section 1373.62 of the Health and Safety Code.

(b) After June 30, 1991, the following amounts shall be deposited annually in the Major Risk Medical Insurance Fund:

(1) Eighteen million dollars ($18,000,000) from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

(2) Eleven million dollars ($11,000,000) from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund.

(3) One million dollars ($1,000,000) from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund.

12739.1. Except as provided in Section 12739.2, the board shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions, and to cover expenses relating to Section 10127.15, or to Section 1373.62 of the Health and Safety Code. The board shall determine the amount of funds expended for each of these purposes, taking into consideration the requirements of this part, Section 10127.15, and Section 1373.62 of the Health and Safety Code.

12739.2. From money appropriated by the Legislature to the fund, the board may expend sufficient funds to carry out the purposes of this part and of Section 10127.15 and Section 1373.62 of the Health and Safety Code.

However, the state shall not be liable beyond the assets of the fund for any obligations incurred, or liabilities sustained, in the operation of the California Major Risk Medical Insurance Program or for the expenditures described in Section 10127.15 and Section 1373.62 of the Health and Safety Code.

12739.3. Any moneys remaining in the fund at the end of any fiscal year may be carried forward to the next succeeding fiscal year.

12739.4. The board shall establish a reserve which is sufficient to prudently operate the program.